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EVALUATING MEDICARE SUBVENTION IN THE MILITARY HEALTHCARE SYSTEM

by

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September 1999

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EVALUATING MEDICARE SUBVENTION IN THE MILITARY HEALTHCARE SYSTEM

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ABSTRACT

The primary research question addressed in this thesis was: "How will the Military Health System and Medicare benefit from Medicare Subvention?" The research described the health care legislation affecting the demonstration project, titled Tricare Senior Prime. Tricare Senior Prime seeks to provide better health care services for dual-eligible military retirees without shifting costs to the DoD or Medicare. While Tricare Senior Prime adds to the health care options of dual-eligible military retirees it also adds administrative complexities to Tricare. The health care services provided under the Medicare package are compared to Tricare Care Senior Prime. Medicare does not provide long term nursing care or custodial care, and certain other health care needs such as dental care, eyeglasses, hearing aids, and most outpatient prescription drugs. Tricare Senior Prime is an attractive low cost alternative to dual-eligible military retirees searching for affordable health care. The DoD believes that it can provide health care services to dual-eligible military retirees at a lower cost than Medicare.

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I. INTRODUCTION

A. NATIONAL HEALTHCARE OVERVIEW

No industry in the 1990s has experienced such phenomenal growth and environmental turbulence as the American health care delivery system. The 1995 Bureau of Census data indicates that health care expenditures have quadrupled since 1995 and now represent about 14 percent of the Gross Domestic Product.[1] Factor in the reversal of economic incentives, a technological revolution, regulatory changes, eroding public trust, and government-led reform initiatives with health care's exponential growth, and turmoil is the term that best describes what today's health care professionals are facing. [Ref. 1]

The health care delivery system uses significant national resources. Total 1993 spending from all sources was $884 billion, a sum that presents 14 percent of the Gross Domestic Product, an average of $3,300 was spent for every man, woman, and child in the nation. In 1965, medical expenditures were only 6.2 percent of Gross Domestic Product; from 1965 to 1993 expenditures grew between 5 and 16 percent every year (USDHHS, 1994). Health care financing from state and local governments is approximately 44 percent of total expenditures and increasing. At the federal level, the Department of Health and Human Services, with funding and oversight administer the Medicare and Medicaid programs from Congress. As medical treatment has grown more sophisticated, effective and popular, it has also became more expensive. Most health insurance is not really "insurance" as the word is commonly used, but prepayment for future medical services. [Ref. 2]

B. NATIONAL HEALTHCARE EXPENDITURES

In 1997, national health care expenditures were $1.1 trillion; per capita spending just short of $4000 dollars per citizen. Health care spending as a share of Gross Domestic Product fell slightly to 15 percent, the smallest claim of health care spending on the nation's resources in the last few years. From 1993-1997, slow health care spending

[1] Gross Domestic Product is the market value of all final goods and services produced within a nation's borders in a given time period.

growth, combined with solid increases in Gross Domestic Product, halted the steady upward path of health care spending as a share of Gross Domestic Product observed over the last past three decades. The share of health care spending financed from public and private sources inched closer together in 1997, continuing the trend begun in 1990. Private funding paid for 53.6 percent of health care ($583.3 billion), down from 59.5 percent in 1990; public programs funded 46.4 percent ($507.1 billion), up from 40.5 percent in 1990. Although public spending growth still exceeded private spending growth in 1997, growth differences between these two payer sectors narrowed to 1 percentage point, down from a differential of 7.4 percentage points as recently as 1994. [Ref. 3]

Per capita expenditures for personal health care goods and services grew at a 3.9 percent average annual rate from 1995 to 1997.[2] Growth can be divided into three measurable factors: economy-wide inflation as measured by the Gross Domestic Product chain type price index, medical price inflation beyond economy-wide inflation ("excess" medical inflation) and a residual that includes changes in volume and intensity of services, and any measurement error. In the period 1995-1997, the non-price factors, such as volume and intensity of service usage, grew at essentially the same rate as they had since 1990. Hospital and physician expenditures traditionally account for the majority of personal health care spending. However, the percentage of health care expenditures being spent on these services has been declining in recent years. Home health care growth also decelerated due to public sector actions to rein in extraordinary expenditure growth for those services. Prescription drugs grew at double-digit rates during the last few years, because of increases in the number of new, higher priced drugs entering the marketplace, increased consumer demand induced by drug manufacturer advertising and an increase in the number of prescriptions filled. [Ref. 4]

The recent slower growth of national health care expenditures has been driven mostly by decelerating public sector spending, primarily expenditures for Medicare and Medicaid. In 1997, Medicare financed $214.6 billion for health care for its 38.4 million aged and disabled enrollees. The Medicare program is the largest public payer for health

[2] Per Capita GDP is the dollar value of GDP divided by total population.

care. In the last four years, annual growth in Medicare spending has slowed markedly, from 12.2 percent in 1994 to 7.2 percent in 1997.

Of the $585.3 billion spent by private sources for health care in 1997, about 60 percent (348.0 billion) was spent on private health care insurance premiums. In 1997, private health care insurance premiums grew just 3.2 percent, down slightly from the 4.0 percent growth registered in 1996. A significant factor in the slowing private health care insurance premium growth during the 1990s has been that employers and employees are migrating away from more expensive traditional fee-for-service health care plans into lower average cost managed care arrangements. In 1997, more than 85 percent of those enrolled in private insurance plans were in some type of managed care plan. [Ref. 5]

When examined on a per enrollee basis, Medicare and private health care insurance benefits (personal health care expenditures) have actually grown at comparable annual rates from 1969 through 1997 (10.4 and 11.4 percent respectively). In the last two years, Medicare per enrollee growth has been trending down, while growth in private health care insurance per enrollee has trended up, substantially narrowing the gap between the two. In 1997, Medicare per enrollee spending grew 5.8 percent, compared with 4.4 percent for private health care insurance costs. [Ref. 6]

The below table lists national health care expenditures.

NATIONAL HEALTHCARE EXPENDITURES AGGREGATE AND PERCAPITA AMOUNTS, PERCENT DISTRIBUTION, AND AVERAGE ANNUAL PERCENT GROWTH BY SOURCE OF FUNDS: SELECTED CALENDAR YEARS 1960-97										
	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997
Amount in Billions										
National Health Expenditures	$26.9	$73.2	$247.3	$428.7	$699.4	$766.8	$836.5	$898.5	$1042.5	$,092.4
Private	142.5	254.5	416.2	448.9	483.6	513.2	524.9	538.5	561.1	585.3
Public	104.8	174.2	283.2	317.9	353.0	385.3	422.8	455.2	481.4	507.1
Federal	72.0	123.2	195.2	222.5	251.8	275.4	301.2	326.0	348.0	367.0
State and Local	32.8	51.0	88.0	95.4	101.2	110.0	121.6	129.2	133.4	140.0
Number in Millions *U.S. Population*	235	247	260	263	265	268	271	273	276	278
Per Capita Amount										
National Health Expenditures	$1052	$1735	$2690	$2918	$3151	$3350	$3500	$3637	$3781	$3925
Private	606	1030	1601	1708	1821	1913	1938	1971	2035	2103
Public	446	705	1089	1210	1330	1437	1561	1666	1746	1822
Federal	306	498	751	847	948	1027	1112	1193	1262	1319
State and Local	140	206	338	363	381	410	449	473	484	503
Percent Distribution										
National Health Expenditures	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private	57.6	59.4	59.5	58.5	57.8	57.1	55.4	54.2	53.8	53.6
Public	42.4	40.6	40.5	41.5	42.2	42.9	44.6	45.8	46.2	46.4
Federal	29.1	28.7	27.9	29.0	30.1	30.6	31.8	32.8	33.4	33.6
State and Local	13.3	11.9	12.6	12.4	12.1	12.2	12.8	13.0	12.8	12.8
Percent of Gross Domestic Product										
National Health Expenditures	8.9	10.3	12.2	13.0	13.4	13.7	13.6	13.7	13.6	13.5
Average Annual Growth from Previous Years										
National Health Expenditures	12.9	11.6	10.3	9.6	9.1	7.4	5.5	4.9	4.9	4.8
Private	12.1	12.3	10.3	7.9	7.7	6.1	2.3	2.6	4.2	4.3
Public	14.2	10.7	10.2	12.3	11.0	9.2	9.7	7.7	5.7	5.3

Table 1.1 National Health Care Expenditures[3]

C. SECTION 733 STUDY OF THE MILITARY MEDCIAL CARE SYSTEM

During the 1990's, the Department of Defense Health Affairs (DOD (HA)) completed two major initiatives to improve health care services to military beneficiaries. The first initiative was the *"733 Study."* In Section 733 of the National Defense Authorization Act of Fiscal years 1992 and 1993, Congress mandated that DoD analyze the peacetime and wartime health care requirements. The second initiative was to implement the Tricare program. Tricare is a "triple option" Health Maintenance Organization structure, which encourages patients to participate in more efficient managed care programs. [Ref. 7]

The "733 Study" was conducted to determine the wartime mission for the Military Health System in the post-Cold War era and determine how to provide beneficiaries cost-effective health care services in peacetime. The wartime mission was adjusted to reflect current defense policy, which calls for the capability to fight two nearly simultaneous major regional conflicts. Although the study adopted a number of conservative assumptions, the resulting estimates of wartime requirements are substantially lower than those based on Cold War scenarios. More specifically, the study found that Military Treatment Facilities' (MTFs) capacity is currently far above projected wartime requirements, in contrast to the situation during the Cold War. In the "733 Study," Health Affairs had not considered the backup capacity provided by the Department of Veterans Affairs or even the National Disaster Medical System. Had this capacity been considered, wartime requirements would have been even lower and the excess Military Health System (MHS) capacity even higher.

The peacetime portion of the study examined the economics of sizing the Military Health System. To determine if care provided in Military Treatment Facilities is more cost-effective than care received under the *Civilian Health and Medical Program of the Uniformed Service (CHAMPUS)* model, Health Affairs estimated what would happen to total medical costs if the capacity of the Military Treatment Facilities expanded to "recapture" the care provided in the private sector under CHAMPUS. The analysis

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[3] Source: Health Care Financing Administration, Department of Health and Human Services, Highlights of National Health Expenditures, 1997, Health Care Financing Administration, June 1998

concluded that, for individual treatment episodes, it costs less to provide care in the Military Treatment Facilities than through CHAMPUS. Therefore, recapturing CHAMPUS workload on a one for one basis would lower costs. [Ref.8]

The study concluded that improving access to health care services at Military Treatment Facilities would increase total health care costs, because savings from recapturing individual cases would be more that offset by increases in the volume of care provided at Military Treatment Facilities. The principal reason for this finding is that improved access would encourage some "ghost" beneficiaries to re-enter the Military Health System and forgo receiving health care services from other non-DoD sources. This would leave DoD to pay for the care that third-party health care plans would otherwise have paid. In addition, health care use rates among beneficiaries are higher when they receive care at the Military Treatment Facilities. Health care in Military Treatment Facilities is virtually free to beneficiaries and military physicians tend to deliver more health care than private sector physicians.

Downsizing the Military Health System to wartime requirements might raise concerns about preparedness in the event of larger future requirements. Exploiting the substantial hospital capacity for extended care through contingency agreements with the Department for Veterans Affairs and the National Disaster Medical System should help to allay some of those fears. Reliance on the civilian hospital system could be increased if Health Affairs instituted improvements, such as a tracking system for patients evacuated from the combat theater. [Ref.9]

Aside from the availability of this additional capacity, there are other reasons why sizing the Military Health System to wartime requirements need not jeopardize the medical readiness mission. The lessons learned from medical operations in Operations Desert Shield and Desert Storm strongly indicate that the size of the military medical infrastructure is only one factor in determining the wartime readiness of the Military Health System. Just as important is medical readiness training that medical personnel must receive during peacetime to fulfill their wartime mission of providing non-combat medical care and the evacuation of casualties from theater.

If the DoD determines that the current Military Health System must be retained because of peacetime requirements, its ability to perform the wartime mission could be

hampered. Although the overall number of physicians in the military currently is nearly double what is needed to meet wartime requirements, the composition of the medical force in peacetime differs from that required for wartime. One of the obvious differences is in the types of physicians required to offer a Health Maintenance Organization-type benefit package centered on the Military Health System, as Tricare Prime creates. [Ref. 10]

Delivering peacetime, health care services cost-effectively requires a greater reliance on clinical specialists in areas such as internal medicine, obstetrics, geriatrics, and gynecology, and less on the general practitioners needed to serve the wartime mission. The total number of peacetime diagnoses that train military physicians for war represents a very small percentage of the patient diagnoses at the Military Treatment Facilities. [Ref. 11]

D. DEFENSE HEALTH PROGRAM OVERVIEW

The Military Health System is a large and complex organization with multiple responsibilities. Health care services are provided to millions of active-duty personnel and other beneficiaries through a worldwide system of hospitals and Tricare. The Military Health System also operates a 4-year medical university and an extensive graduate medical education program, to train physicians and other health care professionals to provide combat medical care. Additionally, the Military Health System conducts medical research on a wide range of social and environmental diseases, and oversees several hundred medical personnel on operational assignments around the world. Through these activities, DoD responds to its two primary missions: wartime readiness, that is, maintaining the health of service members and treating wartime casualties; and peacetime care, providing for the health care needs of the families of active-duty members, retirees and their families and survivors. These missions are carried out with an annual budget of more than $15 billion, representing about 6 percent of the total defense budget. [Ref.12]

According to a draft of Health Affairs Medical Readiness Strategic Plan, the military medical organization exists to support combat forces in war, and in peacetime to

maintain and sustain the well-being of the fighting forces in preparation for war. Military medical personnel care for wounded and ill personnel in combat areas. The Military Health System also contributes to maintaining the forces' readiness by providing medical care to active duty military personnel not involved in combat operations, including routine preventive care as well as treating injuries and illness. In recent years, the U.S. military role, and the mission of the medical departments, has expanded to include peacekeeping and humanitarian missions. They include deployments to Bosnia, Somalia and Haiti and care to the victims of Hurricane Andrew, the Los Angeles earthquake, and the California floods. [Ref. 13] Wartime medical readiness is the primary mission of the Military Health System; however, caring for families and retirees represents the bulk of health care services provided. These non-active duty patients comprise almost 80 percent of the 8.3 million people eligible for health care services. The number of eligible beneficiaries will decline slightly through the year 2000; active-duty forces are declining while the number of retiree families is increasing.

Each Branch of Service has its own medical department headed by a Surgeon General. Each of the Services medical departments prepares a medical program budget for the Assistant Secretary, develops Service specific programs within the guidance and parameters established by Health Affairs and operates the Services medical facilities. Each Service also recruits and funds its own medical personnel to administer to its medical programs and provide medical services to beneficiaries. [Ref. 14]

Health Affairs develops the Defense Health Program budget consistent with guidance and direction from the DoD Program Analysis and Evaluation (PA&E) Directorate and the DoD Comptroller. The $15-billion Defense Health Program accounts for about 6 percent of DoD's total operating budget. The Defense Health 1998 Program Objective Memorandum (POM) shows that total obligational authority is projected to increase by about $2.7 billion, or 18 percent, from $15.1 billion in 1997 to $17.8 billion 2003, in current dollars. The Program Objective Memorandum reflects no program growth when expressed in constant dollars. Health care costs are the third largest of eight infrastructure categories, after installation support and central training, and are expected to remain the third largest for the foreseeable future. Most of the medical infrastructure category consists of the Defense Health Program. DoD projects that the program will

represent about 6 percent of DoD's total budget through at least fiscal year 2003. [Ref. 17]

Although the DoD budget is discretionary, active duty and retired military personnel and their family members consider the Defense Health Program to be an integral part of their employment and retirement benefits package. Beneficiaries may receive health care through DoD's new managed health care system titled Tricare. They may use DoD Military Treatment Facilities and/or one of three options under Tricare. *Retirees and family members over age 65 are not eligible for Tricare because they receive Medicare benefits. However, they may receive health care in DOD medical treatment facilities on a space-available basis.* For this reason, the Defense Health Program is regarded somewhat as an entitlement program. Direct care (patient care provided in DoD Medical Treatment Facilities) is very inexpensive to the beneficiary.

The majority of the Defense Health Program budget is for total patient care. In fiscal year 1998 estimates, patient care accounted for $11.2 billion of the $15.5 billion budget. Patient care includes both medical care for active duty personnel and their dependents and healthcare benefits received by retired military personnel and their family members. Direct patient care, which the DoD provides in Military Treatment Facilities, is the largest portion of the Defense Health Program budget. The estimated Total Obligational Authority (TOA) for direct care is projected to increase by about 16 percent, from $6.9 billion in fiscal year 1997 to $7.9 billion in fiscal year 2003.

Patient care that is purchased or provided under contract is projected to increase by 31 percent, from $3.5 billion to $4.6 billion. Other budgets categories within the Defense Health Program are also projected to increase, but to a smaller extent. For example, patient care support is projected to increase by 23 percent. Patient care support includes management headquarters, military public and occupational health, veterinary services, examining activities, the aeromedical evacuation system, and the Armed Forces Institute of Pathology. In the 1998 Program Objective Memorandum, DoD projects that Total Obligational Authority for all patient care both care in Military Treatment Facilities and government-funded care from civilian providers will increase 21 percent, from $10.8 billion in fiscal year 1997 to $13.1 billion in fiscal year 2003. These totals include care provided directly in DoD facilities, managed care provided through contracts, the former

CHAMPUS fee-for-service health care plan, and care provided in non-DoD facilities such as emergency rooms or Uniformed Services Treatment Facilities. [Ref. 18]

Direct care is the largest portion of the patient care budget category and is projected to continue as the dominant category through fiscal year 2003. However managed care support spending is also projected to expand. Health care support contracts under Tricare are projected to increase by 67 percent, from $2.4 billion to $4 billion, while the CHAMPUS portion is projected to decrease, from $1 billion to about $514 million.

Among all users of the Military Health System, DoD projects a slight decrease in the share of active duty personnel and their family members and a slight increase in the share of retirees and their family members between fiscal year 1997 and 2003. Of user patients, 61 percent are projected to be active duty personnel and their dependents in fiscal year 1997 compared to 59 percent in 2003. However, retired military and their family members who use the system are projected to increase as a percentage of the user population, from 39 percent in fiscal year 1997 to 41 percent in fiscal year 2003. [Ref.19]

The Military Health System share of DoD's Total Obligational Authority has increased from 1.7 percent 30 years ago to 6.2 percent in recent years. Although the historical data show an upward trend in the Defense Health portion of the total DoD budget, DoD projects a flat 6.2 percent share of Total Obligational Authority from fiscal year 1996 to fiscal year 2001. DoD has a history of underestimating its medical program budget authority. DoD officials attributed this problem to the difficulty in estimating CHAMPUS costs. For eight of the twelve fiscal years since 1986, DoD's health program has received additional funds above those budgeted. Either reprogramming funds or supplemental funding addressed the understated budgets. [Ref. 20]

The Defense Health Program budget uses a *capitation-financing model* that estimates per capita health care costs on the basis of the user population, adjusted for gender and age and other factors such as inflation. The budget is constructed under the guidance and direction of the DoD Comptroller and Program Analysis & Evaluation. [Ref. 21]

E. RESEARCH QUESTIONS

The primary research question is: "How will the Military Health System and Medicare benefit from the Medicare Subvention demonstration program?" Subsidiary questions to be addressed include:

- Will access to Military Treatment Facilities improve for dual-eligible military retirees enrolled in the Medicare Subvention demonstration program titled Tricare Senior Prime?
- Will Medicare dual-eligible military retirees receive a more comprehensive health care package under Tricare Senior Prime?
- Will the federal government realize cost saving from Tricare Senior Prime?

F. SCOPE

This thesis will examine the benefits to the Military Health System and Medicare under Tricare Senior Prime. It will review and analyze the benefits of Tricare Senior Prime to the federal government. Specifically, it will focus on whether Medicare reimbursement from the Department of Health and Human Services to the DoD for providing health care services to dual-eligible military retirees occur without shifting costs between agencies.

G. METHODOLOGY

Archival research methods were primarily used to gather data for this thesis, sources used are identified in the list of references. In addition, this thesis draws on telephone interviews and guidance from medical personnel at Naval Medical Center, San Diego, California and from the Director of Program Evaluation, Tricare Management Activity.

H. BENEFITS OF THE STUDY

This study will provide an overview of the Medicare Subvention demonstration project titled Tricare Senior Prime within the DoD and Department of Health and Human Services. Furthermore, the findings may help Commanding Officers of Military Treatment Facilities in understanding how Medicare Subvention and Tricare Senior Prime fit into the overall health care strategy in managing their Medical Treatment Facilities.

II. HEALTH CARE LEGISLATION AFFECTING MEDICARE SUBVENTION

Chapter II describes health care legislation affecting the Medicare Subvention demonstration project, titled Tricare Senior Prime, its purpose and intent. This description will provide the framework necessary to assess the demonstration project's impact within the DoD and Health Care Financing Agency.

A. BACKGROUND

Dual-eligible military retirees currently receive "space available" health care services for little or no charge. Military retirees made up 8 percent of the total patient population eligible for health care services when the DoD was initially granted authority to provide services during the Cold War period. The Military Health System was sized for a large active-duty force, with enough excess patient capacity that military retirees were almost assured Military Treatment Facility access on a "space-available" basis. However, downsizing the Military Health System, coupled with increases in the military retiree population, have reduced the availability of Military Treatment Facility access and health care services. [Ref. 22]

Tricare has also affected "space-available" access available in Military Treatment Facilities. Tricare provides patients enrolled in the Tricare Prime, Health Care Maintenance Organization priority over other patient categories. However, dual-eligible military retirees aged, 65 or older, are ineligible for Tricare Prime enrollment; they can only obtain access on a "space-available" basis. Therefore, as Tricare Prime enrollment continues to expand, access to Military Treatment Facilities will worsen for dual-eligible military retirees. DoD pays most of the health care cost for retirees under age 65, who receive health care services from private health care providers through the CHAMPUS program. The CHAMPUS program was established in part so retired military members and their family members would have comprehensive health care coverage until eligible for the Medicare program at age 65. Dual-eligible military retirees lose CHAMPUS health insurance coverage at age 65. [Ref. 23]

When space and resources are not available in Military Treatment Facilities, these older military retirees must depend on non-DoD sources, including Medicare, Department of Veterans' Affairs facilities, and other government-sponsored or private health insurance programs. Using a mixture of Military Treatment Facilities and other health care sources has created a patchwork system that dual-eligible military retirees must navigate to receive health care services. "Space available" care is extremely episodic and lacks the regularity and continuity essential for geriatric patients, who have more frequent and chronic medical problems. Although dual-eligible military retirees may also access care through Medicare and private supplemental health insurance, many dual-eligible military retirees experience coverage gaps and high out-of-pocket expenses. The Military Treatment Facilities ability to care for dual-eligible military retirees will continue to diminish and eventually disappear in many locations as Tricare Prime patient enrollment increases. This will leave many dual-eligible military retirees without DoD sponsored health care. [Ref. 24] There are various legislative proposals to enhance health care services and access for dual-eligible military retirees, including the following legislative proposals:

- Enroll dual-eligible military retirees in Tricare Senior Prime and pay for their care with Medicare funds;
- Use DoD funds to pay retirees' Medicare "Part B" premiums and to furnish Medigap policies;
- Provide the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as a Medicare supplement;
- Extend the Federal Employees Health Benefit Program (FEHBP) to medicare-eligible retirees as a Medicare supplement and use DoD funds to pay part of the premium;
- Expand DoD's current mail order prescription drug program to dual-eligible military retirees that do not live near Military Treatment Facilities.

The Balanced Budget Act of 1997 (H.R. 2015) authorized the DoD to establish the Tricare Senior Prime project on a demonstration basis. Tricare Senior Prime permits dual-eligible military retirees to enroll in Tricare Prime with reimbursement from the

Health Care Financing Agency. Since then, the 106th Congress passed several bills to enhance care provided to dual-eligible military retirees. Information on the status of legislation was drawn primarily from http://www.thomas.loc.gov.

B. BALANCED BUDGET ACT OF 1997 (H.R. 2015)

The Balanced Budget Act of 1997 authorizes the Medicare Trust Fund to reimburse the Secretary of Defense for health care services provided to dual-eligible military retirees or family members. The Secretary of Defense must credit all monies received from the Medicare Trust Fund to the medical appropriation. The aggregate amount to be reimbursed under the agreement is limited to $50,000,000 for calendar year 1998, $60,000,000 for calendar year 1999 and $65,000,000 for calendar year 2000. The project is limited to six designated sites and no new Military Treatment Facilities can be built or expanded with funds from the Medicare Trust Fund.

C. UNIFORMED SERVICES RETIREE AND DEPENDENTS HEALTH CARE AVAILABILITY ACT (H.R. 1067) 106TH CONGRESS 1st SESSION

Mr. Thornberry introduced the Uniformed Services Retiree And Dependents Health Care Availability Act (H.R. 1067) on March 10, 1999; it was referred to the Committee on Ways and Means and to the Committees on Commerce, Armed Services and Government Reform. The bill amends Title 10, United States Code to improve access to MTFs for military retirees and their family members. The bill permits Medicare reimbursement for health care services provided to retired military members and allows retirees to enroll in the Federal Employees Health Benefits Program.

D. VETERANS HEALTH CARE IMPROVEMENT ACT of 1999 (H.R. 1347) 106TH CONGRESS 1st SESSION

Mr. Pickering introduced the Veterans Health Care Improvement Act of 1999 on March 25, 1999. It was referred to the Committee on Ways and Means, and to the

Committees on Commerce, Armed Services, and Veteran Affairs. This bill provides for a Medicare subvention demonstration project for veterans and improves DoD's Tricare Senior Prime program, among other provisions.

E. MEDICARE SUBVENTION PROJECT FOR MILITARY RETIREES AND DEPENDENTS (H.R. 1413) 106TH CONGRESS 1st SESSION

Mr. Hefley introduced the Medicare Subvention Project for Military Retirees and Dependents (H.R. 1413) on April 14, 1999. This bill would amend title XVII of the Social Security Act to expand and make permanent the Medicare Subvention Demonstration project for dual-eligible military retirees and family members. The project will be expanded to 16 sites on January 20, 2000.

F. MEDICARE SUBVENTION FOR MILITARY RETIREES AND DEPENDENTS (S. 915) 106TH CONGRESS 1st SESSION

Mr. Gramm introduced the Medicare Subvention for Military Retirees and Dependents (S. 915) on April 29, 1999. This bill would amend title XVIII of the Social Security Act to expand and make permanent the Medicare Subvention Demonstration project for military retirees and their family members.

G. SUMMARY

The initial mandate for implementing the Medicare Subvention demonstration program, titled Tricare Senior Prime, has been followed by other recent legislative actions in the House of Representatives and Senate. Tricare Senior Prime seeks to provide better health care services, enhanced access, greater customer satisfaction and lower out of pocket cost; without adversely affecting other beneficiaries. These objectives must be accomplished without increasing or shifting costs to the DoD or Health Care Financing Agency. While Tricare Senior Prime adds to the health care options of dual-eligible military retirees it also adds administrative complexities to

Tricare such as the need for new contracts with Medicare, Health Care Maintenance Organizations.

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III. THE HEALTH CARE FINANCING ADMINISTRATION

Chapter III provides an overview of the Medicare program, which provides health care insurance to millions of older and disabled Americans. Medicare is perhaps the nation's most cherished entitlement program. Medicare consists of two primary parts: Hospital Insurance (HI), known as "Part A," and Supplemental Insurance (SI), known as "Part B." A third part of the Medicare program titled "Part C," is the Medicare+Choice program. Chapter III provides an in depth analysis of health care services under the Medicare benefit package later; these benefits will be compared to the Tricare Senior Prime benefit package. The data in this chapter was drawn heavily from [Ref. 25].

A. BACKGROUND

Medicare legislation in 1965 established a health care insurance program for aged persons to complement their retirement, survivors, and disability insurance benefits under Title II of the Social Security Act. Title XVII of the Social Security Act is commonly known as "Medicare."

When Medicare began on July 1, 1966, an estimated 19.1 million people were enrolled in the program covering beneficiaries age 65 and older. By the end of 1966, 3.7 million people had received at least some health care services covered by Medicare. In 1973, other beneficiary groups became eligible for Medicare benefits. Benefits were granted to people who had been eligible for Social Security or Railroad Retirement disability benefits for at least 24 months; persons with End-Stage Renal Disease requiring continuing dialysis or kidney transplant; and certain otherwise non-covered aged persons who elected to buy into the Medicare program.

Medicare consists of two primary parts: Hospital Insurance (HI), also known as "Part A" and Supplementary Medical Insurance (SMI), known as "Part B." A third part of Medicare, sometimes known as "Part C," is the Medicare+Choice program; which was established by the Balanced Budget Act of 1997 and began providing services on January 1, 1998. Beneficiaries must have Medicare "Part A," and "Part B" to enroll in a "Part C" (Medicare+Choice) plan. In 1997, about 38 million people were enrolled in either "Part

A" or "Part B" of the Medicare program. About 87 percent of all Medicare "enrollees" used some HI and/or SMI services in 1997.

Non-covered services under Medicare include long term nursing care or custodial care, and certain other health care needs-- such as dentures, dental care, eyeglasses, hearing aids, most prescription drugs, etc. These health care services are not a part of the Medicare program unless they are part of a managed care plan, or -- after January 1, 1999-- are selected as a part of the Medicare+Choice program.

B. MEDICARE COVERAGE

Hospital Insurance "Part A" is generally provided automatically to person's age 65 and over that are entitled to Social Security or Railroad Retirement Board benefits. Similarly, individuals who have received such benefits based on a disability, for a period of at least 24 months, are also entitled to Hospital Insurance "Part A" benefits. In 1997, the Hospital Insurance "Part A" program provided protection against hospital and other specific medical costs to about 38 million people. The Hospital Insurance "Part A" benefits totaled $137.8 billion in 1997, an increase of 7.1 percent over the prior year; the average expenditure per Hospital Insurance "Part A" enrollee was $3,600, an increase of 6 percent over 1996 costs. The following sub-paragraphs list the health care services covered under Medicare's Hospital Insurance "Part A."

- **Inpatient Hospital** care coverage includes costs of a semi-private room, meals, regular nursing services, operating and recovery room, intensive care, inpatient prescription drugs, laboratory tests, x-rays, psychiatric hospital, inpatient rehabilitation, and long-term care hospitalization when medically necessary, as well as all other medically necessary services and supplies provided in the hospital. An initial deductible payment is required, plus co-payments for all hospital days following day 60 within a benefit period.

- **Skilled Nursing Facility** care is covered by HI only if it follows within 30 days of a hospitalization of three or more days, and is certified as medically necessary. Covered services are similar to those for inpatient hospital, but also include rehabilitation services and appliances. The number of Skilled Nursing Facility days provided under Medicare is limited to 100 days per benefit period with a co-payment required for days 21 through 100. Medicare

HI does not cover nursing facility care at all if the patient does not require skilled nursing or skilled rehabilitation services.

- **Home Health Agency** care including care provided by a home health aide, may be furnished part-time by a home health agency in the residence of a home-bound beneficiary if intermittent or part-time skilled nursing and/or certain other therapy or rehabilitation care is necessary. Certain medical supplies and durable medical equipment may also be provided. There must be a plan of treatment and periodical review by a physician. Home health care under HI has no duration limitations, co-payment, or deductible. For durable medical equipment, beneficiaries must pay a 20 percent coinsurance, as required under SMI of Medicare. Full-time nursing care, food, blood, and drugs are not provided as HHA services.

- **Hospice** care is a service provided to terminally ill patients with a life expectancy of six months or less who elect to forgo the standard Medicare benefits for treatment of a traditional medical treatment, and receive only hospice care. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services and symptom management for a terminal illness. However, if a hospice patient requires treatment for a condition that is not related to the terminal illness, Medicare will pay for all covered services necessary for that condition. For the hospice program, the Medicare beneficiary pays no deductibles, but does pay a very small coinsurance amount for drugs and the cost of inpatient respite care.

C. SUPPLEMENTARY MEDICAL INSURANCE (SMI)

Supplementary Medical Insurance benefits are available to almost all resident citizens age 65 or older, even to those who are not entitled to Health Insurance Medicare services based on eligibility for Social Security or Railroad Retirement benefits and disabled beneficiaries who are entitled to Medicare's Health Insurance. Supplemental Medical Insurance coverage is optional and requires a monthly premium. Most beneficiaries entitled to Health Insurance also choose to enroll in Supplemental Medical Insurance. In 1997, the Supplemental Medical Insurance program covered the costs of physician and other medical services for about 36 million people. Approximately 87 percent of these beneficiaries received medical services covered by Supplemental Medical Insurance during 1997, with Supplemental Medical Insurance benefits of $72.8 billion paid on their behalf.

Supplemental Medical Insurance provides coverage for inpatient and outpatient physician services. However, Supplemental Medical Insurance also covers certain non-physician services, including: clinical laboratory tests, durable medical equipment, most supplies, diagnostic tests, ambulance services, flu vaccinations, prescription drugs which cannot be self-administered, certain self-administered anticancer drugs, some other therapy services, certain other health services, and blood which was not supplied by Health Insurance.

The expenditures for institutional services in hospital outpatient departments, ambulatory surgical centers and certain other centers are also covered, along with Home Health Agency services. To be covered, all services must either be medically necessary or be a prescribed preventive benefit. Certain medical services and related care are subjected to special payment rules, including deductibles (for blood); maximum approved amounts (for independently practicing, Medicare-approved physical or occupational therapists); or higher cost-sharing requirements (such as that for outpatient treatment for mental illness).

D. MEDICARE+CHOICE (PART C)

Medicare+Choice is another option provided by the Balanced Budget Act of 1997; Under the Balanced Budget Agreement, Medicare beneficiaries who have both "Part A" and "Part B" can choose between a variety of risk-based plans, known as "Part C" of Medicare. To participate in "Part C," beneficiaries must be entitled to Health Insurance and be enrolled in Supplemental Medical Insurance. As is the case for risk plans, organizations seeking to contract as Medicare+Choice plans are:

- Coordinated care plans, which include Health Maintenance Organizations, Provider-Sponsored Organizations and Preferred Provider Organizations, and other certified public or private coordinated care plans and entities that meet the approved required standards as set forth in the law

- Private unrestricted fee-for-service plans, which allow beneficiaries to select private providers. For those providers who agree to accept the plan's payment terms and conditions, this option does not place the providers at risk, nor vary payment rates based upon utilization.

- Medical Savings Account (MSA) plans, which allow beneficiaries (only a limited number for the first five years) to enroll in a plan with a high deductible (maximum for 1999=$6,000). The federal government pays a prescribed portion of the capitation amount into an insurance fund for each enrollee. The difference between the Medicare capitation rate and the plan premium is deposited into the MSA account. Deposits for the entire year are made at the start of the year. After the deductible is paid, the MSA plan pays providers 100% of amounts payable under the fee-for-service Medicare program.

E. MANAGED CARE PLANS

Managed care plans function on a different financial basis from the traditional fee-for-service reimbursements to health care providers. Under managed care plans, the Medicare beneficiary selects a specific Health Maintenance Organization, Competitive Medical Plans, or other approved plan within a service area for comprehensive health care services. It is central to the managed care concept that this selected plan coordinates all of the health care services for the beneficiary. Managed care plans receive a per-person payment from Medicare that is predetermined, based on both a formula established by law and the demographic characteristics of the Medicare beneficiaries enrolled in their plan.

In addition to the regular services covered under Medicare, the managed care plans often cover services such as preventive care, prescription drugs, eyeglasses, dental care, and hearing aids. Electing to participate in a managed care plan may also serve as an alternative to purchasing "Medigap insurance," which is often attractive if the beneficiary has traditional fee-for-service coverage. Although there are certain restrictions, limitations and differences from fee-for-service plans, managed care's fixed monthly premiums and cost-sharing structure provide more predictable out-out-pocket costs for beneficiaries who do not have Medigap insurance.

F. PROGRAM FINANCING

Financial operations are handled through two trust funds, one for Health Insurance "Part A" and one for Supplemental Medical Insurance "Part B". These two

trust funds are special accounts in the U.S. Treasury and are credited with all income receipts and charged with all Medicare expenditures for benefits and administration costs. Assets not needed for payments are invested in special Treasury securities. The Health Insurance "Part A" is financed primarily through a mandatory payroll deduction known as the "FICA tax." Almost all employees and self-employed workers in the U.S. pay taxes to support the cost of Health Insurance "Part A" benefits for aged and disabled beneficiaries. The FICA tax is 1.45 percent of earnings (paid by both the employee and employer), as well as 2.90 percent for self-employed persons.

The trust fund for the Health Insurance "Part A" also receives income from: (1) a portion of the income taxes levied on Social Security benefits paid to high-income beneficiaries, (2) premiums from beneficiaries who are not otherwise eligible and choose to enroll voluntary, (3) general fund reimbursements for the cost of certain uninsured individuals, and (4) interest earnings on the trust fund's invested assets. Taxes paid each year are used mainly to pay benefits to current beneficiaries. Health Insurance "Part A" trust fund money is used only for the Health Insurance "Part A" program; the Supplemental Medical Insurance "Part B" trust funds cannot be transferred for Health Insurance "Part A" use.

Supplemental Medical Insurance, "Part B," is financed through (1) premium payments ($43.80 per month in 1998), which are usually deducted from the monthly Social Security benefit checks of Supplemental Medical Insurance "Part B" program enrollees, and (2) through contributions from the general revenue of the U.S. Treasury. Supplemental Medical Insurance "Part B" benefits may also be "bought" for a beneficiary if a third party directly pays the monthly premium on behalf of the enrollee. Beneficiary premiums are currently set at a level that covers 25 percent of the average expenditures for aged beneficiaries. Except for a small amount of interest income, general revenues fund provide the balance of Supplemental Medical Insurance "Part B" benefits.

The Medicare "Part C" program (Medicare+Choice) has rather complex financing, depending upon which plan is selected. The funding for the Medicare+Choice program essentially comes from the Health Insurance "Part A" and Supplemental Medical Insurance "Part B" trust funds in proportion to the relative weights of Health Insurance

"Part A" and Supplemental Medical Insurance "Part B" benefits to the total benefits paid by the Medicare program.

G. MEDICARE REFORM

The following paragraphs draw heavily from the National Bipartisan Commission on the Future of Medicare [Ref.26,27,28]. The commission has proposed several Medicare reforms. The Medicare program is expected to become insolvent in about a decade, as the huge Baby Boomer generation begins to almost double the number of eligible beneficiaries; there are currently about 39 million beneficiaries.

H. COMPETITION IN MEDICARE

The National Bipartisan Commission's proposal envisioned preserving the traditional fee-for-service Medicare that has been a cornerstone of Americans retirement since 1965, but sought to expand private sector options, increasing participation by Health Maintenance Organizations and other managed care plans. In that way, the plan would make Medicare more like the health benefits that many companies and the federal government offer to government workers. Retirees could choose from a menu of health-insurance policies, and receive a subsidy to help cover the cost. The more expensive plans would require participants to pay more out of their own pockets. Meanwhile, the government-run system that now serves most retirees would compete with the private health plans, forcing the government program to offer similar coverage.

The competition among private health plans to attract elderly customers and their Medicare subsidies could help the program save money and adapt to rapid technology changes, supporters claim. For people choosing private plans, the federal government would pay about 80 percent of the cost of a typical basic plan. This concept, mirroring the menu of health options available to federal workers, is known, as "premium support." is a form of a voucher.

Currently, Medicare directly pays most beneficiaries' medical bills. In contrast, if Medicare adopted premium support, insurance companies of all kinds--not just managed

care--could compete for government contracts to provide a basic benefit package. Medicare would negotiate with the plans to obtain the best possible deals, then set an annual subsidy based on a percentage of the average bid. For example, if Congress decided Medicare should pay 80 percent of enrollee's insurance premiums, and the plan's average bid was $5,000, the government subsidy would be $4,000 a year. Retirees could end up paying significantly more or less than $1,000, however, because individual premiums would vary. Plans offering extra perquisites might be more expensive. Critics contend the premium support plan resembles a voucher system, and erodes the elderly's basic entitlement to health care. The bipartisan commission had also considered a proposal to charge more affluent patients more for their medical care, known as "means testing." But this is considered untenable. Means testing would have the biggest financial effect of the strategies the commission was considering, saving nearly $100 billion by 2009.

Dedicating tax surpluses to Medicare: President Clinton has promised to dedicate 15 percent of budget surpluses over the next 15 years to Medicare; this is the centerpiece of his proposal to fix Medicare. The administration says Clinton's plan would pump $650 to $700 billion into Medicare, enough to keep it solvent for another 20 years. Critics view the plan as a Band-Aid that would set back the reform process by putting off needed structural reform to a time when change would be even harder.

Increase eligibility age: The plan also would gradually raise the eligibility age from 65 to 67. Proponents of raising the age claim that improvements in medicine and in lifestyles make the average 65-year-old American healthier today than when Medicare was instituted in 1965. As a result, they believe that Medicare could realize significant savings by raising the eligibility age, without a seriously degrading the well being of 65- and 66-year-olds, relative to their status in 1965.

Coverage of prescription drugs: One of the most controversial issues has been prescription drug coverage, which is excluded from traditional Medicare coverage. Advocates argue that government health insurance has a responsibility to provide drugs that not only can improve and prolong recipients' lives but can reduce the need for expensive hospital and nursing home stays. Opponents argue it's irresponsible to expand

the already overburdened Medicare system with a huge new entitlement that would cost an estimated $15 billion to $309 billion a year.

Currently, Medicare does cover prescription drugs for inpatients, but does not pay for outpatient prescription drugs unless the beneficiary belongs to a Health Maintenance Organization. As a result, as many as one-half of Medicare recipients pay for their prescriptions on their own at a time when medication costs are rising sharply. The commission's approach would require private insurance companies to offer at least one option that includes drug coverage. The popular private plans that supplement Medicare coverage, known as Medigap, would also be required to cover prescription drugs. Drugs would be available through the traditional Medicare program too, but the beneficiaries would have to pay for the extra cost.

Waste and fraud: Government auditors reported that Medicare actually lost about seven cents of every dollar spent to fraud, waste and mistakes in 1998. While that amounts to more than $12 billion, it's only about half of what was lost by the government's health insurance program just two years ago. That improvement reflects reforms begun in 1993, when the government cracked down on Medicare. Since then, the fraction of the program's 860 million bills a year that are audited has risen from 5 to 14 percent. The Justice Department is also working more closely with Medicare auditors to investigate suspicious claims and prosecute suspected fraud cases. An Inspector General's report by the Department of Health and Human Services found that markups for 22 drugs cost Medicare hundreds of millions of dollars annually. Medicare paid more than twice the average wholesale price for certain drugs; in one instance Medicare paid roughly 10 times the wholesale price.

I. SUMMARY

Medicare provides health care insurance for aged persons to complement their retirement, survivors, and disability insurance. At age 65, dual eligible-military retirees are eligible to participate in the Medicare program. Medicare, however, does not provide long term nursing care or custodial care, and certain other health care needs such as dental care, dentures, eyeglasses, hearings and most outpatient prescription drugs. Such

health care services are not part of Medicare unless they are part of a managed care plan or Medicare+Choice "Part C." Thus, Tricare Senior Prime is an attractive low cost alternative to dual-eligible military retirees searching for affordable health care.

IV. TRICARE SENIOR PRIME

Chapter IV describes Tricare Senior Prime, its purpose and intent. The DoD believes that it can provide health care services to dual-eligible military retirees through Tricare Senior Prime's, Health Maintenance Organization at a lower cost than Medicare's, Health Maintenance Organization. This contention is based on Health Affairs "*733 Study,*" which compared the cost of providing health care services to DoD beneficiaries in the Military Health System with the cost of providing health care in the private sector. Additionally, Chapter IV explains the mechanics of Tricare Senior Prime, particularly its benefits to dual-eligible military retirees. The data in this chapter was gathered primarily from [Ref. 29,30].

A. LEGAL AUTHORITY AND PARTICIPATION IN TRICARE SENIOR PRIME

Tricare Senior Prime is conducted under the authority of the Social Security Act, (section 1896) and amended by the Balanced Budget Act of 1997 (P.L. 105-33 section 4015). [Ref. 31] Participants in Tricare Senior Prime must have Medicare "Part A" and "Part B" coverage. Additionally, beneficiaries must be eligible for care from the DoD under Title 10 United States Code 1074 (b) or 1076 (b). The Department of Health and Human Services authorizes the DoD to enroll dual-eligible military retirees in the Medicare Subvention Demonstration project titled Tricare Senior Prime. Tricare Senior Prime will become the exclusive source for health care services for enrolled beneficiaries and enrollees must pay a cost share payment. Dual-eligible military retirees who select Tricare Senior Prime will be subject to all Medicare+Choice "Part C" requirements, including the "lock-in" provision, which prevents participants from using their fee-for-service benefits. [Ref. 32]

B. SITES SELECTED AND POPULATION COVERED

Tricare Senior Prime is currently offered at only six sites. The catchment areas for San Antonio, Fort Sill, and Sheppard Air Force Base are combined into one site during the Medicare Subvention Demonstration project. [Ref. 33] The participating sites are listed below:

- Keesler Air Force Base, Biloxi, Mississippi
- Wilford Hall Medical Center and Brooke Army Medical Center, San Antonio, Texas
- Fort Sill, Lawton, Oklahoma and Sheppard Air Force Base, Wichita Falls, Texas
- Fort Carson and the Air Force Academy, Colorado Springs, Colorado
- Madigan Army Medical Center, Fort Lewis, Washington
- Naval Medical Center San Diego, San Diego, California
- Dover Air Force Base, Dover Delaware

C. BENEFITS TO DUAL-ELIGIBLE MILITARY RETIREES

Tricare Senior Prime health care services must be better or no worse than Medicare's benefit package. Dual-eligible military retirees should receive better health care services, improved access, enhanced customer satisfaction and lower out of pocket costs under Tricare Senior Prime. In this regard, the DoD should examine the levels of satisfaction, health status, and access between those enrolled versus those not enrolled and between those in the demonstration areas versus those outside the demonstration areas. Data obtained from Health Care Surveys submitted by dual-eligible retirees can be used to assess levels of satisfaction, access, and health status. [Ref. 34] The below table describes the health care services provided under Tricare Senior Prime.

SERVICES	BENEFIT	YOU PAY WITH CIVILIAN PROVIDER	YOU PAY AT MTF
Medical Expenses Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and other services.	Unlimited if medically necessary	$12 per visit (or $12 each for bills from separates entities coincident to a visit).	Nothing
Mental Health Outpatient	Unlimited if medically necessary	$25 per visit	Services not normally available at MTF
Clinical Laboratory Services	Unlimited if medically necessary	$12 per set of lab services (Nothing if provided as part of an office visit)	Nothing
Durable Medical Equipment and Supplies	Unlimited as long as you meet Medicare conditions	20% of fee negotiated by the contractor for durable medical equipment	Nothing; however availability may be limited at MTF
Outpatient Hospital Treatment	Unlimited if medically necessary	$30 for emergency room visit (waived if admitted) $25 co-payment for ambulatory surgery	Nothing
Blood	Unlimited if medically necessary	No additional cost beyond visit	Nothing
Pharmacy	Unlimited if medically necessary	$9 per prescription	Nothing
Clinical Preventive Services	Age specific schedule to be determined, similar to Prime for younger enrollees	Nothing	Nothing
Hospitalization (except mental health) Semiprivate room and board, general nursing and other hospital services and supplies	Same as Medicare	$11 a day ($25 minimum)	Nothing
Mental Health Hospitalization	Same as Medicare 190 day per lifetime	$40 per diem	Inpatient mental health services not normally available at MTF
Home Health Care Part-time or intermittent skilled care, home health aide services	Unlimited as long as you meet Medicare conditions	Same as Medicare: Nothing for services	Services not normally available at MTF

Table IV.1 Tricare Senior Prime Benefits

SERVICES	BENEFIT	YOU PAY WITH CIVILIAN PROVIDER	YOU PAY AT MTF
Hospice Care Pain relief, symptom management and support services for the terminally ill	Unlimited as long as doctor certifies need	Same as Medicare for inpatient respite care: Limited cost for outpatient drugs $9 per prescription	Services not normally available at MTF
Blood When furnished by a hospital or skilled nursing facility during a covered stay	Unlimited if medically necessary	No additional cost beyond hospitalization	No additional cost beyond hospitalization

Table IV.1 Tricare Senior Prime Benefits[4] Continued

D. IMPACT ON OTHER DOD BENEFICIARIES

Providing comprehensive health care services for dual-eligible military retirees may have an adverse effect on the Military Health System and hinder access for active duty personnel and their family members. Tricare Senior Prime goal is to demonstrate that a new health care benefit could be established without negatively impacting other patient categories. [Ref. 35]

E. LEVEL OF EFFORT

The DoD will compute the historical expenditures for Medicare eligible beneficiaries, known as *Level of Effort*. Expenditures will be computed separately for each Medicare Subvention Demonstration site. Expenses will be accumulated from a population perspective; totaling all applicable Defense Health Program (DHP) expenses for all dual-eligible military retirees living in the zip codes defining the site, regardless of where in the Military Health System those expenses were incurred. The Balanced Budget Agreement requires each test site spend the amount they would have spent without the demonstration on dual-eligible military retirees' health care, before Medicare reimburses

[4] Source: Medicare Demonstration of Managed Care, Memorandum of Agreement between the Department of Health and Human Services, the Health Care Financing Administration, the DoD, the Office of the Assistant Secretary of Defense to conduct a three year Medicare Subvention demonstration project for dual-eligible military retirees.

the DoD under Medicare Subvention. The DoD already receives funding for its care of dual-eligible military retirees as part of its annual appropriation. Health Affairs does not have an patient level accounting system that can measure the detailed cost of health care services provided to any category of patients. Therefore the DoD developed a complex method to estimate *Level of Effort* or baseline accepted by the Health Care Financing Administration (HCFA). It is critical that *Level of Effort* be correctly calculated. If underestimated, Medicare may overpay. DoD would have to reimburse the overpayment. Using 1996 data, DoD currently estimates its *Level of Effort* for the six sites to be $172 million. The Balanced Budget Agreement caps payments to DoD at $50 million in the demonstration's first year, $60 million in the second year, and $65 million in the third year in order to protect the Medicare Trust Funds. [Ref. 36]

F. TRICARE SENIOR PRIME COSTS

Tricare Senior Prime costs must be *budget neutral* to both the DoD and the Health Care Financing Agency. Specifically, Medicare Subvention should reflect that budget neutrality was achieved and that cost was not shifted from the DoD to Medicare--that the Medicare trust funds did not experience any losses. This analysis should include the Level of Effort that DoD expends for the Medicare eligible patients as well as any reimbursements from Medicare that may be triggered during the demonstration. Medicare Subvention should ascertain if DoD can in fact live within Medicare reimbursements, and whether the area specific level of Medicare reimbursements determines this ability. Further, Medicare Subvention should highlight any cost shifting within DoD to accommodate health care services for Tricare Senior Prime patients, both between regions and among medical programs. For Medicare Partners payments, analyses should estimate the extent to which Graduate Medical Education (GME), Indirect Medical Education (IME), and Disproportionate Share Hospital (DSH) amounts are included in those reimbursements. Both Departments should be able to forecast future budget impacts if the demonstration is continued or expanded.

Data for this analysis will be obtained in the same manner that Level of Effort was determined for reimbursement purposes. Source documents include inpatient,

outpatient, and ancillary medical records along with Medical Expense Performance Review System accounting data. Because some beneficiaries shift across regions and medical programs, some aggregate data will need to be analyzed from outside the demonstration regions. [Ref. 37]

G. REIMBURSEMENT

For each demonstration year and each demonstration site, DoD and Health Care Financing Agency will establish a threshold for triggering interim payments during the demonstration year, expressed as a total annual dollar amount. The annual threshold will be 30 percent of the site's *Level of Effort* during the first demonstration year (pro-rated for the actual number of months of care delivery at each site), 40 percent during the second year, and 50 percent in the third. The total annual amount will be used to establish monthly dollar thresholds for triggering interim reimbursement. The monthly threshold at each site will be one-twelfth the annual threshold amount. For each demonstration month, Health Care Financing Agency will determine what it would pay each site for all enrollees, using the modified per capita reimbursement threshold for a site, then Health Care Financing Agency will reimburse DoD for the amount over the threshold. If the amount that Health Care Financing Agency should pay the site is less than the monthly reimbursement threshold, the DoD will not receive any reimbursement for that site for that month. Skilled nursing facility and home health costs, not a DoD benefit, paid by DoD for enrollees below the *Level of Effort*, will be counted toward the *Level of Effort*.

The reimbursement rate by Medicare to DoD is 95 percent of the applicable Medicare+Choice rate for each county, and will be adjusted to remove payments for graduate medical education (GME), indirect medical education (IME) and Disproportionate Share Hospital (DSH). In accordance with the agreement by both Secretaries, 67 percent of capital payments will be removed. If requested by DoD and authorized by law, the Secretaries will reevaluate these latter adjustments based upon the recommendations of a demonstration evaluator or another public or private organization mutually acceptable to Department of Health and Human Services and DoD. During the

three years of the demonstration, the evaluation will track the rate and evaluate it against the primary goals of the demonstration.

At each the end of each demonstration year, Department of Health and Human Services and DoD will conduct a reconciliation process. The reconciliation will determine whether DoD is entitled to retain reimbursements that they received under this demonstration and to determine the amount that they should retain. The reconciliation will not adjust for under payments or overpayment that result from inefficiency or efficiency. Health Care Financing Agency currently pays Medicare Health Care Maintenance Organizations a flat fee for each enrolled beneficiary that is equal to 95 percent of Medicare's estimated average cost of treating a similar beneficiary in the fee-for-service sector. Under this proposal, DoD has agreed to accept the payment rate the Health Care Financing Agency pays to private Medicare, Health Maintenance Organizations. After the first year, the Health Care Financing Agency's payment rate would be further reduced by excluding allocations for Graduate Medical Education, indigent care, and capital costs—costs that DoD does not incur or for which it is separately funded. DoD has estimated that, because of these adjustments, the resulting payment rate could be 7 to 13 percent less than the rates Health Care Financing Agency pays private Medicare Health Care Maintenance Organization's. [Ref. 38]

H. PROHIBITION AGAINST INCREASING MEDICARE COST

Tricare Senior Prime can not increase the total cost of Medicare over what the cost would have been without Medicare Subvention. If the Medicare expenditures increase during a fiscal year because of Tricare Senior Prime, both Secretaries shall take corrective steps as may be needed to recoup the increases for the Medicare program and to prevent any such increases in the future. Corrective action will include paying for the increased expenditures from the current DoD medical appropriation, the suspension or termination of the demonstration project or lowering DoD's of payment. [Ref. 39]

I. JOINT ANALYSIS OF COST, UTILIZATION AND OTHER DATA

Both Departments will jointly analyze utilization patterns and cost prior to and during Tricare Senior Prime. The Department of Health and Human Services, Secretary will have access to all data necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project. [Ref. 40]

J. SUMMARY

The Medicare Subvention Demonstration project's stated goal is to implement a cost-effective alternative for delivering accessible and quality health care services to dual-eligible military retirees while not increasing cost to either DoD or Medicare. In principle, all parties involved should gain under Tricare Senior Prime. Dual-eligible retirees who choose DoD's plan can use their Medicare benefit to receive care at Medical Treatment Facilities. Under Medicare Subvention, Medicare's payment for enrollees could be less than what it pays private plans serving other Medicare beneficiaries, and DoD could gain additional funds and use excess capacity where it exists.

V. STRATEGIC PLANNING & MEDICAL READINESS

Chapter V provides an overview of strategic planning and medical readiness as it relates to the Military Health System and Navy Medicine. The political realities of the 1990s and the next decade require leadership to anticipate and take actions to effectively and efficiently serve its beneficiaries and numerous stakeholders. The Military Health System must be committed to continuously improving its wartime support and integrated health care delivery system. This leadership challenge can only be handled through *visionary* strategic planning. Strategic planning is ultimately about purpose, meaning, value and virtue. It also leads to a clear mission statement, which is a declaration of the Military Health System's purpose. The Military Health System's current strategic plan/ mission statement does not mention Tricare or Medicare Subvention specifically in its mandate. The Bureau of Medicine Surgery's does reflect a commitment to Tricare.

A. INTRODUCTION

The foreword of the Military Health System's strategic plan, endorsed by the Assistant Secretary of Defense, Health Affairs and the Surgeon General, states:

> The Military Health System is positioned to be the benchmark health care delivery system of the 21st Century emphasizing ***readiness, health promotion, and managed care*** for all Armed Forces personnel, their families and others eligible for care. This strategic plan demonstrates the commitment of our Tri-Service teams to face, together, the challenges inherent in our changing roles and missions, as well as those being brought on by revolutionary changes within the health care community. These joint efforts support and promote collaboration, team building, reengineering across the continuum to enhance quality, curb costs and ensure to all entrusted to our care.

The Military Health System strategic plan contains six goals: Joint Medical Readiness; Benchmark Health System; Healthy Communities; Resources and Structure; Training and Skills Development and Technology Integration. [Ref. 41]

B. MISSION, VALUES AND VISION

1. Mission

The Military Health System supports the DoD and national security by providing health support for the full range of military deployments and sustaining the health of members of the Armed Forces, their families and others to advance national security interests.

2. Values

The Military Health System is dedicated to traditional military values of **duty, honor, courage, and loyalty** in service to our Nation. The Military Health System is faithful to the following values. *Integrity*: Doing the right thing, for the right reasons, with credibility and candor. *Commitment*: Selfless service, loyalty to others, and performance anchored by principle. *Excellence*: Outstanding performance of duty characterized by technical and tactical proficiency, imagination, and innovation in a climate of continual leaning.

3. Vision

The Military Health System is an enterprise, which provides health support for the Nation's security by doing the below:

Strategies

- *Fields* a uniquely trained, equipped, and qualified team to meet the health needs of the fighting forces anytime, anywhere.
- *Projects* military health forces worldwide to advance our national security interests.
- *Promotes* a model health care system valued by commanders, and all other we serve.
- *Functions* as an integrated and accountable health team.
- *Develops leaders* through continuous individual and organizational learning.
- *Takes advantage* of research and technology to advance health and readiness.
- *Promotes health* through the best practices of prevention and intervention.

C. GOAL (1) *JOINT MEDICAL READINESS*

Ensure that military members of the Armed Forces attain an optimal level of fitness and health and are protected from the full spectrum of medical and environmental

hazards. Our medical forces will meet the challenges of a rapidly changing continuum of Service-specific, joint, and combined military operations anywhere at anytime by:

Strategies

- *Strive* to improve the health and fitness levels of our Armed Forces on a continuing basis.
- *Deploy* a doctrinally sound medical force that is well trained and equipped to accomplish its mission.
- *Advocate* research and technology that can optimize human performance and enhance force medical protection.

D. GOAL (2) *BENCHMARK HEALTH SYSTEM*

The Military Health System will be the world's best-integrated health care system. The Military Health System spans the continuum of health care from the operational and readiness mission to the delivery of the health benefit. To accomplish this, we must optimize use of the three Service medical departments to meet the Military Health System mission. Only in this way can we be health and fitness-focused and responsive to customer needs where cost, quality, and access are paramount.

Strategies

- Communicate the Tricare benefit so our customers will be educated and responsible consumers.
- *Promote* prevention and wellness as the foundation of the system.
- *Deliver* state-of-the-art, outcome-oriented, compassionate care.
- *Measure* health outcomes and customer satisfaction to identify opportunities for improvement
- *Measure* Military Health System leadership, management, and technical skills.

E. GOAL (3) *HEALTHY COMMUNITIES*

The Military Health System will forge partnerships to create a common culture that values health and fitness and empowers individuals and organizations to actualize those values. The complexity and tempo of military operations requires optimal human performance (reflecting complete physical mental and social well being). In addition,

diminishing resources must be targeted to maintain and promote healthy individuals, workplaces, and communities.

Strategies

- *Utilize* comprehensive, population-based, medical information systems as a foundation for evidence-based disease prevention and health decision making.
- *Develop* partnerships among the Military Health System, other government agencies, and the private sector to create healthier environments and workplaces.
- *Provide* necessary health information to commanders, policy makers, and individuals that can act to influence health and prevent diseases and injuries.
- *Sustain* the prevention culture at home and abroad, in peace and war.

F. RESOURCES AND STRUCTURE

The Military Health System will identify and prioritize resource requirements and establish effective and efficient organizations to support the readiness and benefit missions. The identification and prioritization of resource requirements and efficient organizations is critically important to the ultimate acquisition of resources to support Military Health Support programs.

Strategies

- *Identify* and resource medical readiness requirements to meet the rapidly changing continuum of military operations.
- *Develop* and use analytical models to determine resource requirements for manpower, education and training, facilities, materiel, and equipment.
- *Use cost/benefit analysis* to determine when outsourcing and privatization are appropriate alternatives for achieving the Military Health System.
- *Use best-practice* models to achieve maximum efficiencies.
- *Employ* organizational structures that best support the readiness, efficiency, and effectiveness of the Military Health System.

G. GOAL (4) *TRAINING AND SKILLS DEVELOPMENT*

The Military Health System will train and develop our people for their roles in war and peace. Well-trained people are the bedrock of a successful health system. Achieving our strategic goals will require developing plans to educate, train, and retain highly qualified and diverse personnel at all levels of the system.

Strategies

- *Provide* an integrated system of education, training, and professional development to produce skilled leaders and managers at all levels.
- *Provide* education and training programs to maximize the quality of the medical force.
- *Establish* requirements-based training criteria to support the Military Health System mission.
- *Pursue* opportunities to consolidate, integrate, privatize, and/or outsource training programs.
- *Encourage and support* a policy of inclusion and advancement for persons representing a variety of backgrounds.
- *Promote* technology and innovation for education and training.

H. GOAL (5) TECHNOLOGY INTEGRATION

The Military Health System will integrate technologies into best practices designed to achieve high quality clinical outcomes, decrease health care delivery costs, and improve management processes. To obtain the full benefit of new technology, we are committed to a value analysis of all requirements. For the integration of new technology to truly succeed, we must provide a measurable performance result that is connected to improvement, increases efficiency, information dominance, and mission accomplishment.

- *Identify* the full range of technologies needed to accomplish the Military Health System mission.
- *Plan,* assess, obtain, install, and maintain technologies to provide cost beneficial, interoperable solutions to meet Military Health System requirements.
- *Train* to insert and sustain new technologies.

I. NAVY MEDICAL DEPARTMENT'S STRATEGIC PLAN

The mission of the Navy Medical Department is to support the combat readiness of the uniformed services, promote, protect and maintain the health of all those entrusted to our care. There are four components of the strategic plan: *Force Health Protection, People, The Health Benefit, and Best Business Practices*. Under The Health Benefit component the goal is to communicate the benefit and educate our customers. The specific objectives are listed below: [Ref. 42]

- Informed Customers-Beneficiaries will be knowledgeable about and confident in their comprehensive health benefits.
- Informed Staff-Navy Medical Department staff will be knowledgeable emissaries for *Tricare* and other DoD health services.
- Prepared Leadership-Medical will communicate the information about current issues to their beneficiaries, staff and line organizations.

Under the Best Business Practices the goal is to identify and be the benchmark for sound business practices. The specific objectives are listed below:

- Integrity of data on which business decision are founded is an all hands evolution
- Standardized business case analyses are used to make sound business proposals and decisions
- Best practices are rapidly implemented throughout Navy Medicine

J. THE EFFECT OF MEDICARE SUBVENTION DEMONSTRATION PROJECT ON THE READINESS OF DOD MEDICAL PERSONNEL

The Medicare Subvention Demonstration project could increase the quality of training health care professionals need, particularly physicians and nurses. Primarily providing care to young active duty members and their families weakens the proficiency of physicians and nurses (Uniformed Services Journal, 1995, pp.4-10). Health care professionals must treat a wide variety of patients to meet certification standards and readiness requirements. Dual-eligible military retirees provide a patient population mix other than young healthy active duty members. The conditions that dual-eligible military retirees present to the medical staff provides the closest training available to prepare medical personnel for conditions they may face in overseas Medical Treatment Facilities. Dual-eligible military retirees bring such conditions as thoracic surgery, organ transplant, and urology to the health care provider, making them a critical component of medical readiness. The only training that would be of higher quality is treating actual trauma or combat casualties.

K. THE EFFECT OF MEDICARE SUBVENTION ON RETENTION

Training, job satisfaction, reasonable workloads, and fair compensation are factors that influence the decision of medical personnel to remain on active duty. Trained and experienced health care professionals strengthen the readiness status of the Military Health System. On the other hand, readiness is hampered when experienced health care professionals leave military service.

L. SUMMARY

The Military Health System leadership faces difficult challenges in the turbulent years ahead. Consider, for example, the demographic shifts towards dual-eligible military retirees; compounded by diminishing resources and numerous stakeholders demands to design and implement a major health care plan like Tricare Senior Prime without visionary strategic planning. Unwittingly, military readiness could be hampered if resources consumed in Tricare Senior Prime are not properly managed. The current strategic plan says many of the right things, but there is no methodology to validate that the goals of the strategic plan are being implemented. Technology integration must be fully funded and adopted for the demonstration project to work. The potential benefits of incorporating Tricare Senior Prime into the Military Health System strategic plan are: improved resource decision making; responsiveness and accountability to dual-eligible military retirees; and a more efficient and effective integrated health care delivery system.

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VI. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Chapter VI summarizes the previous chapters and presents conclusions based on researched data. Recommendations for additional study are also provided.

A. SUMMARY

The primary research question addressed in this thesis asked: "How will the Military Health System and Medicare benefit from Medicare Subvention?" To answer this question the following subsidiary questions were addressed:

- Will access to Military Treatment Facilities improve for dual-eligible military retirees enrolled in the Medicare Subvention Demonstration program titled Tricare Senior Prime?
- Will Medicare dual-eligible military retirees receive a more comprehensive health care package under the Tricare Senior Prime?
- Will the federal government realize cost saving from the Tricare Senior Prime?

To answer these subsidiary questions Chapter II described the health care legislation affecting the Medicare Subvention Demonstration project, titled Tricare Senior Prime, including its purpose and intent. The initial mandate for implementing Tricare Senior Prime has been followed by more recent legislative actions in the House of Representatives and Senate. Tricare Senior Prime seeks to provide better health care services, enhanced access, greater customer satisfaction and lower out of pocket cost without adversely affecting other beneficiaries. These objectives must be accomplished without increasing or shifting costs to the DoD or the Health Care Financing Agency. While Tricare Senior Prime adds to the health care options of dual-eligible military retirees it also adds administrative complexities to Tricare, such as the need for new contracts with Medicare Health Care Maintenance Organizations.

Chapter III reviewed the Medicare program, which provides health care insurance to millions of older and disabled Americans. This established Medicare as perhaps the nation's most cherished entitlement program. Medicare consists of two primary parts Hospital Insurance (HI), known as "Part A," and Supplemental Insurance (SI), known as "Part B." A third part of Medicare program, titled "Part C," is the Medicare+Choice

program. Chapter III further outlined the health care services covered under the Medicare benefit package, to support a comparison between the Medicare and Tricare Senior Prime benefit package. Medicare provides health care insurance for aged persons to complement their retirement, survivors, and disability insurance. At age 65, dual-eligible military retirees are eligible to participate in the Medicare program. Medicare however does not provide long term nursing care or custodial care, and certain other health care needs such as dental care, dentures, eyeglasses, hearing aids and most outpatient prescription drugs. Such health care services are not part of Medicare unless they are part of a managed care plan or Medicare+Choice "Part C". Thus Tricare Senior Prime is an attractive low cost alternative to dual-eligible military retirees searching for affordable health care.

Chapter IV reviewed Tricare Senior Prime, its purpose and intent. The DoD believes that it can provide health care services to dual-eligible military retirees through Tricare Senior Prime's, Health Maintenance Organization at a lower cost than Medicare's, Health Maintenance Organization. This contention is based on Health Affairs' "*733 Study,*" which compared the cost of providing health care services to DoD beneficiaries in the Military Health System with private sector health care costs. Additionally, Chapter IV also explained the mechanics of Tricare Senior Prime, particularly its health care plan for dual-eligible military retirees. The Medicare Subvention Demonstration project's stated goal is to implement a cost-effective alternative for delivering accessible and quality health care services to dual-eligible military retirees, while not increasing DoD or Medicare costs. In principle, all parties involved should gain under Tricare Senior Prime. Dual-eligible retirees who choose DoD's plan can use their Medicare benefit to receive care at Medical Treatment Facilities. Under Medicare Subvention, Medicare's payment for enrollees could be less than what it pays private plans serving other Medicare beneficiaries, and DoD could gain additional funds and use excess capacity where it exists.

Chapter V describes strategic planning and medical readiness as it relates to the Military Health System and Navy Medicine. The political realities of the 1990s and the next decade require leadership to anticipate and take actions to effectively and efficiently serve its beneficiaries and numerous stakeholders. The Military Health System must be

committed to continuously improving its wartime support and integrated health care delivery system. This leadership challenge can only be handled through *visionary* strategic planning. Strategic planning is ultimately about purpose, meaning, value and virtue. It also leads to a clear mission statement, which is a declaration of the Military Health System's purpose. The Military Health System's current strategic plan/mission statement does not specifically mention Tricare or Medicare Subvention in its mandate. The Bureau of Medicine and Surgery's strategic plan/mission statement does reflect a commitment to Tricare.

Leadership of the Military Health System faces difficult challenges in the turbulent years ahead. Consider, for example, the demographic shifts towards dual-eligible military retirees this is more problematic when coupled with diminishing resources and numerous stakeholders' demands to design and implement a major health care plan, like Tricare Senior Prime, without visionary strategic planning. Unwittingly, military readiness could be hampered if resources consumed in Tricare Senior Prime are not properly managed. The current strategic plan says many of the right things but there is no methodology to validate that the goals of the strategic plan are being implemented. The potential benefits of incorporating Tricare Senior Prime into the Military Health System strategic plan are: improved resource decision making; responsiveness and accountability to dual-eligible military retirees; and a more efficient and effective integrated health care delivery system.

B. CONCLUSIONS

1. Despite Cost Neutral Intent, Medicare Subvention Poses Financial Risk to the Government

DoD's Medicare Subvention plan attempts to ensure cost-neutrality for both DoD and Medicare in two ways. First, it would require the Military Health System to maintain its current suspending, or "level of effort," on dual-eligible military retirees treated in Military Treatment Facilities. Second, the plan would require that Medicare's payment rate be set lower than the per-person rate Medicare currently pays to private Medicare, Health Maintenance Organizations. If the Military Health System's level of effort was

accurately determined and the Medicare payment rate was appropriately set, neither DoD nor the Health Care Financing Agency would experience increased costs. However, DoD's lack of information systems to accurately determine its current Level of Effort raises questions about whether Medicare Subvention will actually be cost neutral. Furthermore, DoD's capacity and financing constraints could significantly limit the number of older retirees who would benefit from Medicare Subvention. [Ref. 43]

2. Comparatively Few Retirees Would Benefit From Medicare Subvention

Under the current proposal, Medicare Subvention would only be offered to dual-eligible military retirees who live near Military Treatment Facilities. Further, Medicare Subvention would be less financially feasible for Medical Treatment Facilities that had to purchase significant health care services from the private sector using supplemental funds. Each Medical Treatment Facility would have to carry out a financial analysis before starting a Medicare Subvention program to determine the amount and cost of care it would have to purchase. From a financial perspective, many smaller Medical Treatment Facilities could not afford to offer patient enrollment under Medicare Subvention. In its plan for the current Medicare Subvention demonstration at seven Medical Treatment Facilities, the number of enrollees that DoD estimated it could accommodate represents about 20 percent of the dual-eligible military retirees in those areas; DoD expected that a similar proportion could be accommodated under a nationwide implementation plan. On the basis on the number of dual-eligible military retirees living near Military Treatment Facilities with sufficient capacity to operate a Medicare Subvention program, GAO estimates that about 75,000 dual-eligible military retirees could participate nationwide if Medicare Subvention was offered at all but the smallest facilities. [Ref. 44]

3. Uncertainty About MERPS Data Quality Reduces Confidence in Level of Effort Estimates

Facility cost and workload data used to establish DoD's Level of Effort are drawn primarily from DoD's *Medical Expense Performance Reporting System* (MEPRS). MEPRS data are used for many health care services or management purposes such as resource allocation determinations, make-versus-buy decisions (whether to offer a certain product lines or purchase them as needed), setting third-party billing rates, and cost comparisons with private sector systems. Thus, Level of Effort accuracy and key military health care system functions rely in large measure on MEPRS and related data systems to provide accurate, timely, and complete cost and workload information. The DoD acknowledged concerns about MEPRS; DoD officials described MEPRS as a stepchild system that has been under funded and inconsistently used. DoD and the services have not effectively monitored MEPRS to ensure data quality.

GAO identified major concerns with MEPRS, including inconsistent data collection and reporting, service differences in recording depreciation and accounting for readiness expenditures, and the completeness of the accounting for all relevant expenses. In 1992, for example, DoD's Inspector General reported that MEPRS did not track all costs associated with delivering peacetime health care, thereby understating the actual costs of operating and supporting Military Treatment Facilities.

Weaknesses in DoD's cost data can also impair DoD's ability to accurately evaluate alternate approaches to providing care to beneficiaries. Commanders regularly confront make-versus-buy decisions and need reliable business data to decide when to provide care at the Medical Treatment Facility and when to seek private sector alternatives. The "733 Study," drew heavily upon MEPRS data to compare costs. The study's conclusion that DoD's facility costs were generally lower has been challenged and today remains contested. Therefore, it is imperative that MEPRS cost and workload data must be accurate to support day-to-day business decisions. [Ref. 45]

4. Prescription Drug Expenses

Another, source for understating Level of Effort is the adjustment to exclude prescription drug expenses. Medicare generally does not cover outpatient prescription drugs, so the demonstration's Memorandum of Agreement excludes prescription drug cost from the Level of Effort for the six sites. However, DoD accounting systems often do not distinguish between pharmaceutical supplies used in clinic operations, such as chemotherapy drugs, and outpatient drugs. This broad pharmaceutical category amounts to about $17 million in Level of Effort. In removing all expenses in this category, not just that for outpatient drugs, DoD appears to be understating Level of Effort. DoD has not offered a compelling reason for removing the entire amount from Level of Effort. [Ref. 46]

5. Expert Opinions

The following questions concerning the Medicare Subvention demonstration project where asked during a telephone interview with Lieutenant Colonel Thomas Williams, Director, Program Evaluation, and Tricare Management Activity Office. Below is a summary of his questions and answers[5].

- **Question:** How does the DoD provide Tricare Senior Prime enrollment information to HCFA and do our data collection systems now interface with HCFA's?
- **Answer:** We use a fiscal intermediary that has an interface with HCFA and passes the enrollment information data received from our Managed Care Support Contractors (MCSC). There is no direct HCFA interface with our DoD databases.

- **Question (2):** Has Tricare Senior Prime enrollment adversely affected other groups of beneficiaries?
- **Answer:** It is too soon to make any statement about the effect of the demonstration on any categories of our beneficiaries.

[5] The interview was conducted on July 30, 1999.

- **Question (3):** Has Tricare Senior Prime increased cost to DoD or HCFA?
- **Answer:** It is apparent at this point in time that the costs have risen for DoD, I'm not sure about HCFA, but remember that the point of the demonstration is that the costs to the federal government as a total should not rise.

- **Question (4):** If successful will the medical appropriation be reduced?
- **Answer:** The medical appropriation should not be expected to fall in the short term because of the demonstration. We are expected to spend as much as we have in the previous years for subvention dual-eligible military retirees (LOE) before we can keep HCFA payments. Given that, I believe the only way to get at reduced appropriations is to reduce the benefit or change the nature of the demonstration.

Rear Admiral Thomas Corrato, United States Public Health System, chief of staff of the Tricare Management Activity, said in an interview, "DoD's Medicare Subvention program encountered some difficulty in calculating the correct Level of Effort. Medicare reimbursement is not triggered until DoD's previous Level of Effort has been attained --." He also suggested improving cost data, across the Army, Navy and Air Force facilities, "so they are all counting data the same way." In four instances, he said, "Level of Effort calculations had to be revised because of concern by GAO over accuracy. We have been urged by GAO to get some additional outside accounting review of the Level of Effort calculation, and we are doing this jointly with HCFA." (U.S. Medicine, June 1999 p.5)

C. RECOMMENDATIONS

The real challenge for the Medicare Subvention demonstration project is to establish and run a Health Maintenance Organization that meets the requirements of Medicare. To meet its responsibilities, DoD must manage the demonstration project and track its progress toward reaching the Level of Effort target. In addition, like other managed health care plans, DoD must manage costs and resources to maintain access to and quality of care. Data collection is a labor-intensive task and inadequate data systems will undermine Tricare's ability to compete effectively. The demonstration project has a complex payment arrangement, which Medicare and DoD have yet to specify a risk-adjustment method adding uncertainty for leaders. Consequently, the inadequate data systems limit DoD's ability to manage the demonstration and deliver health care.

1. Supplemental Insurance Would Fill Medicare Gaps But be Expensive for the Military Health System

An option to improve health care services for dual-eligible military retirees is for DoD to offer increased insurance coverage beyond that provided through the Medicare program, given the likelihood that many dual-eligible military retirees will be unable to access care from Military Treatment Facilities. However, DoD's costs to provide this additional coverage could be substantial, from $1.6 billion to $2.2 billion per year, depending on the type of supplemental insurance plan offered. Moreover, the costs of these programs would probably rise, with health care costs as a greater number of retirees' reach age 65 and became eligible for the benefits. [Ref. 47]

2. Paying for Medicare "Part B" Premiums and Private Medigap Policies

Upon reaching age 65, military retirees' eligibility for CHAMPUS ends and Medicare becomes the primary insurer. Under Medicare "Part A," which is funded by employer/employee payroll taxes, retirees receive coverage for inpatient hospital, skilled nursing facility home health, and hospice care. Most retirees also purchase Medicare "Part B" (which cost $525.60 per person in 1997), which covers physician visits, outpatient care, laboratory tests, and home medical equipment. However, co-payments and deductibles and limitations in the Medicare benefit, includes exclusions for outpatient prescriptions, foster additional insurance—"Medigap" policies—specifically to fill the gaps in coverage. Supplemental policies can create significant cost for retirees. The annual premiums of plans that cover prescription drugs can range from $750 to almost $3,000, with the more expensive plans generally providing the greatest coverage and filling in more of the in Medicare coverage gaps. Assuming financial responsibility for "Part B" premiums, as well as paying for Medigap policies for all dual-eligible military retirees would cost the DoD and estimated $2.2 billion, or about $1,833 per participant.

This cost estimate is based on a Medigap coverage that includes a prescription benefit. [Ref. 48]

3. Extending CHAMPUS as a Medicare Supplemental Policy

Another option to increase insurance coverage of dual-eligible military retirees is to extend their CHAMPUS coverage beyond age 64. Under this extension, the CHAMPUS benefit would serve as a supplemental policy to Medicare, covering most out-of-pocket costs, outpatient prescription drugs, and medical services included in CHAMPUS but not covered by Medicare. Providing CHAMPUS as a supplemental policy to all dual-eligible military retirees could cost DoD as much as 1.8 billion, or about $1,520 per participant. As a result, beneficiaries would generally have no out-of-pocket expenses for Medicare services. Further, because CHAMPUS is an established program within the DoD, the existing administrative structure could be used after making modifications to various information and claims processing systems. [Ref. 49]

4. Offering Enrollment in the Federal Employees Health Benefit Program to Older Retirees

Another option is to allow dual-eligible military retirees to enroll in the Federal Employees Health Benefit Plan (FEHBP), the nationwide civil service health care plan administered by the Office of Personnel Management. Through Federal Employees Health Benefit Plan, dual-eligible military retirees could select from at least dozen plan options including fee-for-service plans. The insurance premiums would vary depending on the plan chosen and the government and beneficiary shares in the cost of the selected plan. The Federal Employees Health Benefit Plan benefit package offers coverage not covered under Medicare. For example, many of the plans cover prescriptions have catastrophic limits on out-of-pocket cost, and provide some dental benefits. Medicare covers none of these services. Premium amounts, and thus the government and beneficiary costs, are determined by characteristics such as gender mix, health status, and

health care utilization. According to Office of Personnel Management, however, this information has not been developed.

The Medicare subvention demonstration provides DoD and HCFA a valuable opportunity to gauge the effects of treating dual-eligible military retirees in the Military Health System. However, the demonstration payment rules and method of estimating Level of Effort demand accurate, timely, and complete data. DoD's ability to provide such information with its current data systems is questionable. In short, DoD lacks an information system that can produce credible cost data on its individual beneficiaries and beneficiary groups. [Ref. 50]

D. RECOMMENDATIONS FOR FURTHER STUDY

This thesis documented the implementation of the Medicare Subvention demonstration project and it's impact on the DoD and Medicare. Additional areas of Medicare Subvention warrant further research.

- After concluding the demonstration project determine if in fact Medicare Subvention provided better health care services and enhanced access to Military Treatment Facilities for dual-eligible military retirees participating in Tricare Senior Prime.

- Determine if Medicare Subvention increased costs for the Military Health Care System and, if so, where other beneficiaries impacted.

- Examine if the weaknesses in MEPRS has been corrected to ensure data quality. If MEPRS is not corrected, an accurate Level of Effort will not be calculated.

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